LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS
Mailing Address: 7500 Odawa Circle, Harbor Springs, MI 49740
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CHILDCARE ASSISTANCE PROGRAM
WEEKLY TIMESHEET

Parent/Guardian Name:_____
(Please print)

Please print child/Children's first and last name/names.

You must use blue or black ink to complete this form		CHILD 1		CHILD 2		CHILD 3		CHILD 4	
DAY / DATE		Time In	Time Out	Time In	Time Out	Time In	Time Out	Time In	Time Out
Sunday									
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									

Please indicate in the Comments Section if there is a school closing/vacation, or if child was ill and unable to attend school.

Comments: _____

Please round to the nearest 1/4 hour, Example: 7:10 would be rounded up to 7:15, 7:05 would be rounded down to 7:00.

Maximum Payable Hours for children 12 years old and younger is **40 hours per week**.

- I certify that the above information is correct and request payment for the hours of day care used.
- I understand that I can only count those hours that I am working, attending school, or are in an on the job-training program.
- I understand that I can only count those hours that my children are in day care.
- I understand that I am responsible for that portion of day care that is not paid for by the Childcare Assistance Program.
- I understand that the Tribe reserves the right to prosecute for any form of fraud or misrepresentation or error in receipt of benefit.
- I understand that Timesheets turned into the Human Services Department that are found to be incomplete will be held until all information is obtained.
- I understand that I have the option of turning timesheets in on a weekly or monthly basis provided my Day Care Provider is in agreement.
- I understand if I choose to submit timesheets on a monthly basis, they must be received in the Human Services Department no later than five (5) business days after the last day of that month.

This Form must be signed by both the Parent and the Provider, and the date entered CANNOT be before the last day services are rendered.

Parent/Guardian Signature: _____ Date _____

Provider Signature: _____ Date _____

Provider Print Name: _____

Printed Name of Agency: _____